Special Articles and Association Notes

The Manitoba Medical Review

ESTABLISHED 1921

WINNIPEG, MARCH, 1940

Published Monthly by the
MANITOBA MEDICAL ASSOCIATION
Canadian Medical Association, Manitoba Division
Editorial Office
102 MEDICAL ARTS BUILDING, WINNIPEG

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Annual Subscription - $2.00

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Executive Meeting

Summary of minutes of a meeting of the Executive of the Manitoba Medical Association held in the Medical Arts Club on Wednesday, January 31st, 1940, at 6.30 p.m.

Present.

Dr. W. E. Campbell (Chairman)
Dr. Geo. Clingan
Dr. C. W. Burns
Dr. W. W. Musgrove
Dr. E. W. Stewart
Dr. E. J. Skafel
Dr. F. K. Purdie
Dr. Geo. Brock
Dr. H. D. Kitchen
Dr. A. M. Goodwin
Dr. S. G. Herbert
Dr. J. C. McMillan
Dr. E. S. Moorhead
Dr. C. W. MacCharles.

The minutes of the last two Executive Committee meetings held on October 5th and November 6th, 1939, were summarized by the Secretary.

It was moved by Dr. E. J. Skafel, seconded by Dr. H. D. Kitchen: THAT the minutes of the Executive Committee meetings held on October 5th and November 6th, 1939, respectively, be adopted. —Carried.

Business Arising out of the Minutes

Standing Committees.

The secretary read the list of appointments made on the remaining Standing Committees, by the Chairman, as instructed at the last meeting of the Executive Committee.

It was moved by Dr. Geo. Clingan, seconded by Dr. H. D. Kitchen: THAT these appointments be approved. —Carried.

Medical Service Scheme.

The Chairman of the Committee on Economics reviewed the progress of discussions with a group in Winnipeg who were desirous of a medical service scheme, and a motion was passed instructing the Committee on Economics to draw up a tentative schedule of fees with the co-operation of the representatives of Sections of the Winnipeg Medical Society, and submit a report to the Winnipeg Medical Society.

Committee on Fees.

The Chairman of this Committee, Dr. McMillan, presented a progress report. He stated that a copy of the schedule of fees prepared by the Academy of Medicine of Toronto had been printed and given to the various members of the Committee, and some copies had been sent to various general practitioners throughout Greater Win nipeg, and several copies to the Secretaries of the District Medical Societies.

The Committee had met and discussed the problem, also each of the sections of the Winnipeg Medical Society had met later and prepared a tentative schedule of fees for their particular work. These reports had been submitted to a meeting of the Committee and with certain modifications had been accepted.

It was felt that a copy of the schedule as accepted to date should be submitted to the District Societies for consideration, and a meeting be held at which the members of the Fees Committee from the country could attend and discuss the whole report.

Dr. Clingan pointed out that the District Societies outside of Winnipeg and Brandon would not be holding meetings until May, and it was suggested that probably the final decision of the fee schedule would have to be deferred until such time as the District Societies would have an opportunity to discuss this problem.

It was moved by Dr. J. C. McMillan, seconded by Dr. W. W. Musgrove: THAT this report be accepted. —Carried.

It was then moved by Dr. C. W. Burns, seconded by Dr. Geo. Brock: THAT a copy of the tentative schedule of fees be sent to the Secretaries of the various District Medical Societies, asking for comments particularly with regard to mileage, etc. —Carried.

Dr. Moorhead pointed out that the schedule of fees of the Academy of Medicine of Toronto had not been accepted by the Ontario Medical Association.

New Business

Report of Representative on Executive of C.M.A.

In the absence of Dr. Trainor the Secretary summarized the minutes of the last meeting of the Executive Committee of the Canadian Medical Association.

It was moved by Dr. C. W. Burns, seconded by Dr. Geo. Brock: THAT this report be accepted. —Carried.

Members Going Overseas.

It was moved by Dr. W. S. Peters, seconded by Dr. Geo. Clingan: THAT members going overseas with the forces or devoting their full time to services in Canada, be carried as ordinary members of the Manitoba Medical Association for the duration of the war. —Carried.

Municipal Doctors.

This subject was brought up for discussion, and it was decided to secure relevant information and consider the problem again at the next meeting.

Fees for Court Cases.

The question of fees for court cases had been referred to the Executive Committee by the Special Committee on Fees. A motion was passed instructing the President to appoint a Committee to interview the responsible authorities with regard to this problem.

Resignations.

The Secretary read letters received from Dr. Corrigan tendering his resignation as Treasurer of the Manitoba Medical Association, and as a representative on the Cancer Relief and Research Institute.

Dr. A. E. Smith also tendered his resignation as the Brandon and District Medical Society representative on the Executive of the Manitoba Medical Association.

Both these members are on military duty.

Letter from Winnipeg Medical Society re Proposed Survey of Births.

The Secretary read a letter from the Winnipeg Medical Society embodying a resolution passed approving of a proposed survey of births to be undertaken by the Department of Health and Public Welfare: "THAT this Section respectfully suggests that the Department of Health and Public Welfare be requested to institute a study of antenatal, natal and neonatal deaths and still births, similar to that now carried on in the case of maternal deaths."

It was moved by Dr. W. S. Peters, seconded by Dr. S. G. Herbert: THAT this resolution be approved. —Carried.

Letter from Manitoba Hospital Association.

The Secretary read a letter received from the Manitoba Hospital Association advising that they had appointed a Special Committee to study the question of inadequacy of provisions for hospital costs, etc., and asked for the co-operation of the Manitoba Medical Association.

It was moved by Dr. W. S. Peters, seconded by Dr. S. G. Herbert: THAT a Committee consisting of the President (Dr. W. E. Campbell), Dr. O. C. Trainor, Dr. G. S. Fahrni, Dr. A. C. Abbott, the Chairman of the Staff of the Children's Hospital and the Chairman of Staff of the St. Boniface Hospital, be a Committee to meet with members of the Manitoba Hospital Association. —Carried.

OBITUARIES

DR. MICHAEL C. BURKE

Dr. Michael C. Burke died at High River, Alta., on January 1, 1940, on his fifty-first birthday. Born at Fairfax, Manitoba, he graduated from the Manitoba Medical College in 1915, joined the Army Medical Corps and proceeded to France, where he won the Military Cross in 1916. He was sent back to recruit in Brandon, Manitoba, and returned to France in 1917. At the close of the war he practiced in Blackie, Alberta, and later at High River. He is survived by a wife and three children.

Dr. L. J. Loughlin, of Carberry, has kindly sent these notes.

Dr. O. J. Day, Winnipeg, adds that Dr. Burke was wounded and returned to the front and received two bars to the Military Cross. Dr. Day pays tribute to him as one of the bravest men he knew.

DR. PAUL EWERT

Dr. Paul Ewert, 56, former resident of Gretna, Man., died on February 4th at his home in Golden, B.C. Born in Newton, Kansas, he moved to Gretna in 1891 and graduated from McGill in medicine in 1912. He had practiced in Golden since 1914.

DR. HARVEY E. HICKS

Dr. Harvey E. Hicks, aged 76, pioneer medical man of Manitoba, died at Griswold on February 18. He was born at Melford, Ont., and came to Manitoba in 1891, graduating in medicine from Manitoba in 1897. He began practice at Griswold. In 1903 he was elected M.L.A. for Lansdowne. After his term in the legislature he did post graduate work in Great Britain and in 1910 he joined the staff of the Brandon Mental Hospital, becoming Superintendent in 1915. He became a member of the C.A.M.C. in 1918; practiced for about seven years at Oak Lake and in 1926 retired from medicine and devoted his time to farming.

DR. GEORGE W. STAPLES

Dr. George W. Staples died February 23rd at Carman, Man., aged 78. He graduated in medicine from Manitoba Medical College in 1896, and practiced at St. Claude, Man. He was buried in Elmwood cemetery, Winnipeg.

FERROCHLOR *E.B.S.*

Iron is the *oldest* and still one of the most effective treatments for anaemia; but the *most potent form of iron medication* was not definitely known until recently.

In the past, hundreds of organic and inorganic compounds of iron have been tried clinically with widely varying results. This variation of result caused investigators to continue the study of iron absorption in anaemia. Their recent investigations confirmed the previously observed fact that ferrous salts are more readily absorbed than other forms of iron, and that all ingested iron is converted into the ferrous state before absorption. *cf. Journal C.M.A. March '33. Lucas and Henderson.*

F. Hendrych and K. Klimesch, Arch. Exptl. Path. Pharmakol 178, 178-88, 1935, regard ferrous chloride as the physiological form of iron. They find that it does not cause chronic poisoning when administered orally, but that ferrous carbonate and ferric citrate cause characteristic liver damage.

But ferrous chloride is unstable and so unpalatable that many patients refuse to continue treatment long enough to raise the haemoglobin to normal.

Former objections to the use of ferrous chloride have been overcome in Ferrochlor *E.B.S.* which presents ferrous chloride in permanent and palatable form. Each teaspoonful dose of Ferrochlor contains 2 grains of ferrous chloride, equivalent to 30 grains of reduced iron.

"Ferrochlor E.B.S. builds haemoglobin rapidly."

Ferrochlor is also supplied in tablet form for patients who prefer this form of iron medication.

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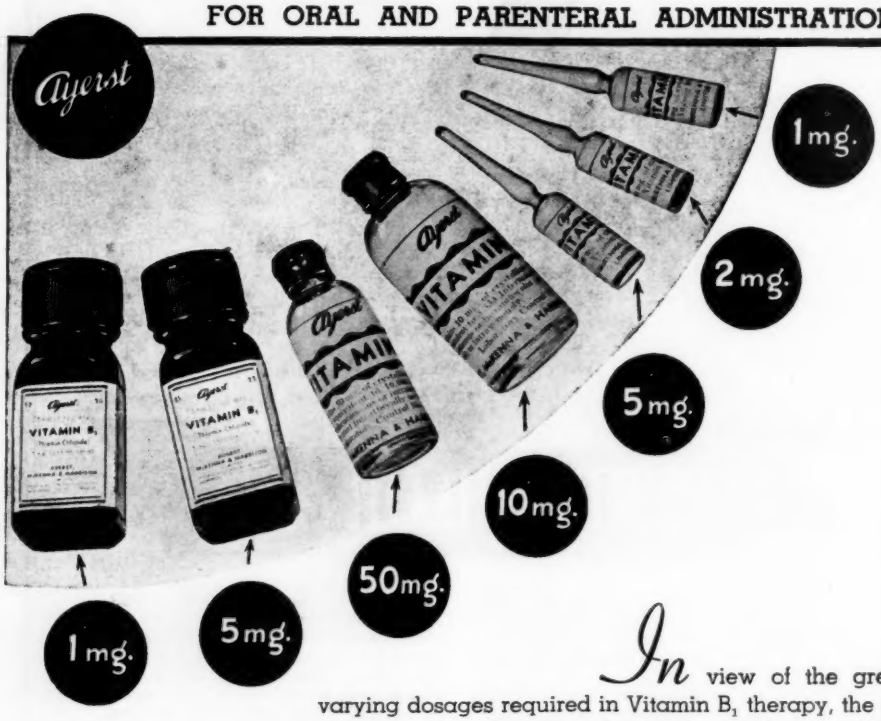

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Department of Health and Public Welfare

NEWS ITEMS

The following is a recent publication in "Preventive Medicine" by Dr. Russell L. Cecil, Professor of Clinical Medicine, Cornell University Medical College, New York City:—

"THE CONTROL OF RESPIRATORY INFECTIONS:

Introduction

"The respiratory infections present one of the most important problems in present day medicine. This statement holds true whether we consider them from the therapeutic standpoint of the practitioner, or from the sanitary viewpoint of the public health officer. The common cold, influenza, pneumonia, and tuberculosis when considered all together, and including their complications, constitute a large bulk of human morbidity. Pneumonia alone ranks third as a cause of death in the United States. Tuberculosis is less prevalent than it formerly was, but still remains a health problem of the first order.

"These fundamental respiratory infections are not only dangerous in themselves, but are doubly serious because of the complications which frequently follow them. Such complications are often merely extensions of the infection from one organ to another, but in other instances the complications are only indirectly related to the preceding respiratory infection. How often the patient with cardiac decompensation or Bright's disease dates the onset of active symptoms to a bad cold or an attack of grippe! We may say then that the devastation which results every year from respiratory infections is only partly the result of the infections themselves. The sequelae can be traced into the domain of most of the chronic systemic diseases.

"The topic which I have been asked to discuss is 'The Control of Respiratory Infections.' This title might be called the expression of an unfulfilled desire, for certainly respiratory infections are far from being under control at the present time. We have learned to control the intestinal infections, but control of respiratory infections is still in the experimental stage. However, important advances have been made along certain lines, notably in the control of diphtheria and tuberculosis. Promising leads are being followed in the fields of coryza, influenza and pneumonia. In the following few pages I shall attempt to present briefly the present status of various preventive measures as applied to acute and chronic respiratory diseases.

"For the sake of convenience, we will divide the topic into: A—Acute Respiratory Infections, and B—Chronic Respiratory Infections.

A—Acute Respiratory Infections

"The acute respiratory infections fall into two groups —the acute upper respiratory infections and the acute lower respiratory infections. Under the first heading come:—

1. Acute coryza.
2. Influenza.
3. Acute tonsillitis and quinsy.
4. Septic sore throat.
5. Diphtheria.
6. Complications of the infections mentioned above.

1. Coryza

"The control of the acute upper respiratory infections may well be called the fundamental problem in the whole field, for if sanitarians knew how to prevent coryza and influenza a very long stride would have been taken toward the elimination of the more serious infections which so frequently complicate these two diseases. Unfortunately, this desideratum has not yet been attained. Indeed, it is only within the last few years that we have obtained accurate information concerning the etiology of these two very prevalent infections.

"With respect to the common cold, the older bacteriologists thought that it was caused by the normal inhabitants of the throat, such as the pneumococcus, staphylococcus, streptococcus, etc. During the last decade, however, interest has shifted from the bacterial inhabitants of the mouth to investigation along the line of viruses.

"The first actual reference to a filterable virus as the cause of colds was by Kruse[1] in 1914, when he reported the isolation of a virus from a patient, and experimental production of colds with bacteria-free filtrates. These experiments were repeated in 1916 by Foster[2] who obtained similar results. A very important addition to our knowledge of viruses in relation to the common cold was made in 1929 when Dochez, Shibley and Mills[3] observed that chimpanzees were susceptible to colds and that these closely resembled the same infection in human beings. They then made the important report that when these animals were inoculated intranasally with bacteria-free filtrates of nasal washings obtained from early human cases of the common cold, the chimpanzees developed typical coryza in 40 per cent. of instances. Later on these observers carried out similar experiments successfully on human volunteers. Most of the experimental colds both in man and in chimpanzees were of a mild character and disappeared within five days, usually without any complications.

"Further knowledge has been gained concerning the virus of the common cold by Dochez and his associates. It survives anaerobically in the cold for at least thirteen days. It is inactivated by a comparatively low degree of heat, and lastly it has been demonstrated to multiply in tissue culture medium of the type used in vaccine virus. Positive experimental infections have been obtained with cultures of the cold virus as many as fifty generations after the original 'seedings.' These findings by Dochez and his associates have been completely confirmed by Powell and Clowes[4] and other investigators, and indicate that the cold virus is similar to other typical filterable viruses that have been previously studied.

"The successful isolation of a virus from patients suffering with coryza has naturally led to attempts to produce an efficient virus vaccine which could be used as a prophylactic against the common cold. Dochez and his co-workers have vaccinated infants and adults with living cold virus and have kept them under observation for a year or more subsequent to vaccination. The results so far have not been sufficiently successful to justify the use of this virus as a prophylactic in man. Strangely enough, it is quite possible to vaccinate a chimpanzee against coryza with the cold virus.

"It is disappointing of course that these first efforts to protect man against colds by means of a virus vaccine have been unsuccessful, but it would not be proper to dismiss this subject without discussing briefly other measures which have been used from time to time for the prevention of colds.

"Bacterial vaccines, either stock or autogenous have been used in prophylaxis against colds since the days of Sir Almroth Wright. There has been much controversy concerning the prophylactic value of bacterial vaccines, and numerous papers have been written pro and con on the subject. A few facts however stand out as a result of these studies:—

1. Bacterial vaccines do not confer an absolute protection against colds. While they are quite effective with many persons, in others the results are disappointing.
2. Bacterial vaccines will reduce the frequency of colds in the majority of patients and will render the colds which do develop of less severity and shorter duration.
3. Bacterial vaccines which contain the prevalent types of pneumococci greatly reduce the incidence of pneumonia in vaccinated individuals. This point has been brought out in a number of studies.

"Autogenous vaccines are indicated in patients who suffer from repeated reinfections from a chronic focus in the respiratory tract, usually in one of the accessory sinuses.

"One of the most rational and successful methods of preventing recurring colds is the surgical elimination of a chronic focus of infection. This will usually be in the tonsils, adenoids, or sinuses, and in such patients tonsillectomy or proper drainage of the infected sinus will often result in complete disappearance of colds.

"Irrigations, sprays, and gargles are of only limited value and should be employed only in bland form. It is possible to sterilize the throat and buccal cavity by means of some of the modern germicides, but within an hour's time the bacteria have again made their appearance and are almost as numerous as they were previous to the irrigation.

"Colds are contagious. Isolation is therefore a rational procedure but difficult to enforce in large cities. However, in the case of children, who are even more susceptible to contagion than adults, isolation is well worth trying. Children with colds in the acute stage should not be sent to school, where they become the vehicle for spreading infection to other children. In many schools, children are sent home when they are discovered with acute colds, and requested to remain away from school until all symptoms have disappeared.

"The so-called 'hardening process,' as a prophylactic method, has not received much support from carefully conducted studies. Bathing in cold water and exposure to cold air may agree with certain very robust temperaments but in other cases might easily predispose to infection. Fresh air minimizes the chance of infection and probably does not affect the susceptibility of the individual. Experience indicates that ample clothing and dry warm shoes are important prophylactic measures. It is common knowledge that cold wet feet will often bring on a cold in the most robust individuals.

"There have been claims in the medical literature that ultra-violet radiation and a high vitamin diet would protect against coryza. Statistical evidence however carried out on college students does not support such statements.

"The author can highly recommend the prompt administration of the popular papaverin and codein capsule when given at the first intimation of a cold. The actual formula is as follows:—

Papaverin hyd.	gr. ¼
Codeine Phos.	gr. ¼
Sodium bicarbonate	gr. iij

Ft. Caps No. 1
Sig.: One capsule q. 3 hours
two capsules at bedtime.

When several of these capsules are taken at the very beginning of a cold, infection can frequently be aborted.

"From time to time the physician will encounter young children whose colds resist all efforts toward prevention. Coryza in these patients may be accompanied by fever and sinus complications. If all other efforts fail, a winter or two in Arizona will frequently work wonders. The child can then return to a northern climate and escape with only the average number of infections.

"Summarizing then, we may say that while a satisfactory virus vaccine has not yet been perfected for the prevention of the common cold, there are other well-tried expedients which experience proves are well worthy of application.

Influenza

"The history of influenza reads very much like that of the common cold. For many years it was generally agreed that the infection was caused by the Bacillus influenzae of Pfeiffer.[5] In 1918 however when the great pandemic of influenza swept over the world, a sharp controversy arose concerning the etiology of the epidemic. Many bacteriologists claimed that they had failed to recover the influenza bacillus from typical cases of influenza and they questioned strongly the etiological relationship of the bacillus to the disease. Other bacteriologists were equally insistent that the Pfeiffer bacillus was the responsible agent. In 1919 Yamanouchi[6] claimed the demonstration of a filterable virus in patients suffering from influenza. The Japanese succeeded in producing what they described as the 'typical disease' by inoculation of nasal washings into healthy volunteers. All previous attempts made by investigators during the great pandemic of 1918 to isolate a virus from influenza patients had been unsuccessful. However, thirteen years later Long and his associates[7] inoculated chimpanzees with washings from a patient with influenza and produced experimental respiratory infection characterized by prostration, fever and leukopenia.

"In 1933 Smith, Andrews and Laidlaw[8] brought forward additional evidence of the virus nature of influenza when they produced an acute febrile infection of the respiratory tract of ferrets by inoculating them intranasally with the filtered washings from cases of influenza in man. Dochez and his co-workers have succeeded in cultivating the virus of influenza on tissue medium.

"The importance of the influenza bacillus in human influenza has not been accurately determined. The studies of Shope,[9] however, on swine influenza, a disease which has many of the characteristics of human influenza, have thrown considerable light on the subject. Indeed it is quite likely that the two diseases are identical, as swine influenza first made its appearance in 1918 at the time of the pandemic of man. Shope first showed that the active agent of swine influenza is a filterable virus. This virus when injected alone into healthy pigs produced a very mild disease. However, when in addition to the virus, the bacillus of swine influenza was added, a very severe and often fatal respiratory infection resulted. The experimental inoculation of the swine influenza bacillus alone produced little or no manifestation of infection.

"The discovery that ferrets, swine and mice are susceptible to the influenza virus has facilitated enormously the study of this disease. Indeed, it is not too much to expect that within the next few years we shall have a fairly complete understanding of the bacteriology and immunology of influenza and quite possibly methods of preventing and controlling the disease. For example, Francis and Magill[10] have shown that, following infection with the virus of influenza, both ferrets and mice develop a state of active immunity against infection. The serums of these animals contain specific anti-bodies as evidenced by the capacity of the serum to confer protection on mice against infection with the influenza virus.

"It is interesting and fortunate that the virus of human influenza can be injected subcutaneously in man without producing the disease. Such procedure for example would be extremely dangerous in the case of poliomyelitis virus. Francis and Magill[11] have found

that human influenza virus could be introduced subcutaneously or intradermally in human individuals without causing evidence of infection. Subjects so treated developed specific anti-bodies against the virus, and the anti-bodies so induced persisted for at least five months. Furthermore, the anti-body response to vaccination paralleled that occurring as a result of the naturally acquired disease.

"Stokes and his co-workers[12] at the University of Pennsylvania recently had an opportunity to test the value of influenza virus vaccine in a state colony of approximately 800 males during an epidemic of influenza in February, 1936. They vaccinated 110 individuals with human influenza virus and 138 individuals with swine virus. 550 controls received no vaccine. The epidemic covered a period of approximately two months. The group vaccinated with human virus showed an incidence of only 2.7 per cent. of febrile respiratory infections, whereas the other two groups showed an incidence of approximately 12.5 per cent. Andrewes[13] has recently made a similar attempt to determine the value of virus vaccination against influenza.

"In vaccinating against influenza a complicating factor has arisen from the fact that not all strains of human influenza virus are pathologically identical. This multiplicity of influenza viruses will no doubt add considerable difficulty to the problem of prophylactic vaccination.

"Bacterial vaccines are practically valueless in the prevention of influenza. This was well brought out during the World War, when attempts to vaccinate large groups of both soldiers and citizens were unsuccessful.

"In the case of influenza, isolation is of even greater importance than it is in coryza, for in the former disease isolation serves a double purpose; it protects to some extent the other members of the family or the social group to which the patient belongs, but still more important, it protects the patient against exposure to super-infection with other pathogenic bacteria which he may readily pick up from contacts, and which in many cases lead to pneumonia or other serious complications.

"In conclusion then, we may say that although little has been accomplished as yet in preventing the spread of influenza, virus vaccine holds out the promise of possessing definite prophylactic value. Furthermore, and most important of all, much can be done to lessen the incidence of serious complications such as pneumonia, by the proper treatment and isolation of the influenza patient."

(To be continued in next issue of "News Items").

COMMUNICABLE DISEASES REPORTED

Urban and Rural — Dec. 31, 1939 - Jan. 28, 1940

Chickenpox: Total 231—Winnipeg 86, Brandon 45, St. Boniface 17, Unorganized 15, MacDonald 10, Kildonan East 9, Portage Rural 8, Brenda 7, Transcona 7, Blanshard 6, Hamiota Rural 2, Kildonan West 2, Silver Creek 2, Argyle 1, Cartier 1, La Broquerie 1, Oakland 1, Pipestone 1, Rockwood 1, Teulon 1, Tuxedo 1 (Late Reported: Brandon 5, Brooklands 1, Hamiota 1).

Measles: Total 228—Winnipeg 148, Fort Garry 24, Flin Flon 15, Tuxedo 11, Portage Rural 7, Unorganized 6, Bifrost 4, Rosser 3, Gilbert Plains Rural 2, The Pas 2, Kildonan East 1, McCreary 1, Rockwood 1, St. Clements 1, Souris 1, Transcona 1.

Whooping Cough: Total 213—Winnipeg 115, St. Boniface 18, Unorganized 18, Brandon 11, Stanley 9, Kildonan East 6, Lawrence 6, Transcona 6, Portage City 5, Brooklands 3, Gimli Village 2, Sifton 2, Flin Flon 1, Fort Garry 1, Hartney 1, Morton 1, St. James 1 (Late Reported: Brandon 4, Brooklands 1, Pilot Mound 1, St. Boniface 1).

Scarlet Fever: Total 91—Winnipeg 40, Woodworth 10, Unorganized 5, Dauphin Town 3, MacDonald 3, Whitemouth 3, Cartier 2, Daly 2, St. James 2, Swan River Town 2, Swan River Rural 2, Assiniboia 1, Dauphin Rural 1, Kildonan Old 1, Kildonan West 1, North Norfolk 1, Rosedale 1, St. Boniface 1, Strathclair 1, Thompson 1, The Pas 1, Woodlea 1, Woodlands 1. (Late Reported: Unorganized 5).

Tuberculosis: Total 65—Winnipeg 12, Brandon 1, Ste. Rose Rural 1, Ste. Rose Village 1 (Late Reported: Unorganized 10, Brandon 5, Tuxedo 4, Dauphin Rural 2, Transcona 2, Bifrost 1, Dauphin Town 1, Elton 1, Flin Flon 1, Harrison 1, Kildonan East 1, Kildonan West 1, Killarney Town 1, Lansdowne 1, Lac du Bonnet 1, Miniota 1, Morris Rural 1, Mossey River 1, Rivers Town 1, Roblin Town 1, Rhineland 1, St. James 1, St. Vital 1, Selkirk 1, Sifton 1, Springfield 1, Strathclair 1, Strathcona 1, Tache 1, Wallace 1, Whitehead 1, Whitemouth 1).

Diphtheria: Total 55—Winnipeg 40, Tuxedo 8, Rhineland 2, Hanover 1, Kildonan West 1, St. Boniface 1, St. Vital 1, Unorganized 1.

Mumps: Total 56—Winnipeg 54, Blanshard 1, Kildonan West 1.

Diphtheria Carriers: Total 39—Winnipeg 32, Tuxedo 4, Fort Garry 1, Kildonan West 1, St. Boniface 1.

Erysipelas: Total 10—Winnipeg 4, Brandon 1, Franklin 1, Kildonan West 1, North Norfolk 1, Stonewall 1, Tuxedo 1.

Influenza: Total 7—Winnipeg 3, Unorganized 3, Kildonan East 1.

Anterior Poliomyelitis: Total 2—Cornwallis 1, Rivers Town 1.

Typhoid Fever: Total 2—Shoal Lake Rural 1 (Late Reported: Roblin Rural 1).

Lobar Pneumonia: Total 2—Brandon 2.

German Measles: Total 2—Rhineland 1, St. Boniface 1.

Septic Sore Throat: Total 1—Wallace 1.

Tetanus: Total 1—(Late Reported: Portage Rural 1).

Venereal Disease: Total 115—Gonorrhoea 81, Syphilis 34 (for month of January).

DEATHS FROM ALL CAUSES IN MANITOBA

For the Month of December, 1939

URBAN—Cancer 42, Pneumonia (other forms) 6, Tuberculosis 6, Pneumonia Lobar 4, Syphilis 4, Diphtheria 1, Influenza 1, Lethargic Encephalitis 1, all others under one year 8, all other causes 190, Stillbirths 10. Total 273.

RURAL—Cancer 18, Pneumonia (other forms) 13, Tuberculosis 10, Whooping Cough 4, Influenza 3, Lethargic Encephalitis 3, Pneumonia Lobar 3, Typhoid Fever 1, Dysentery 1, Tetanus 1, Diphtheria 1, all others under one year 24, all other causes 148, Stillbirths 18. Total 248.

INDIAN—Tuberculosis 7, Pneumonia (other forms) 5, Whooping Cough 2, Pneumonia Lobar 1, all others under one year 9, all other causes 10, Stillbirths 2. Total 36.

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Current Medical Literature

"Journal of The Royal Army Medical Corps"—November, 1939

Preventive Medicine in Relation to Aviation. Air Commodore H. E. Whittingham.

Medical Problems of Aviation. E. Jokl (A Pilot).

Amnesia. Major R. J. Rosie.

Memorandum Concerning the Use of Sulphonamide Derivatives for Prophylaxis and Treatment of Wound Infections. By the Directorate of Pathology, A.M.D. 7, War Office.

"The Journal of Obstetrics and Gynaecology of the British Empire"—October, 1939

Blair-Bell Memorial Lecture. January 27, 1939. Hydatidiform Mole and Chorion-epithelioma. Alan Brews.

Double Monsters in the Light of Recent Biological Experiments and Investigations Regarding Heredity. Contribution to the Problem of the Determination of Sex. Balazs Szendi.

Vaginal Hysterectomy. A New Technique. A Follow-up of 500 Consecutive Operations for Haemorrhage. V. B. Green-Armytage.

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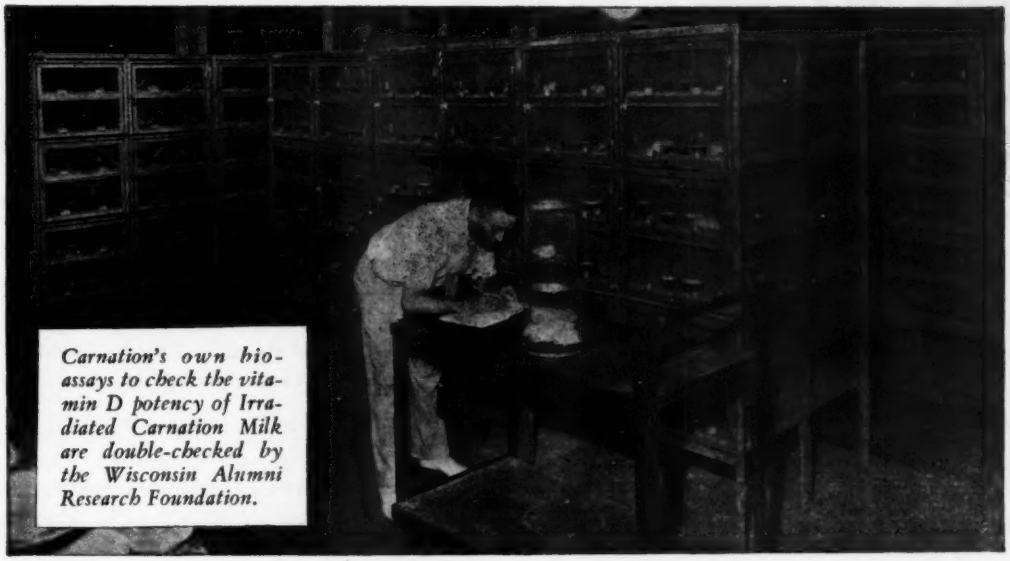

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